VSH FUTURES ADVISORY COMMITTEE
NOVEMBER 16, 2005
Minutes

Next Committee Meeting: January 23, 2006 2:00-4:30pm

Committee Members Present
Anne Donahue, House Human Services Committee; Larry Thomson, VSH; JoEllen Swaine, VSH; John Malloy, VSH; Charlie Biss, VDH; Bea Grause, VAHHS; Kitty Gallagher, AMHSPSC; Linda Corey, VPS; Ed Paquin, VT P&A; Paul Dupre, VT Council; Larry Lewack, NAMI-VT; Peter Tomashow, CVH; Ken Libertoff, VAMH, Conner Casey, VSEA; Nick Emlen, VT Council – sub; Anne Jerman, VSH; Michael Sabourin.

Guests
Alecia Weiss, VCDR; Bob Pierattini, FAHC; Michael Hartman, WCMHS; Chuck Booth, NFI; Rick Palmisano, Retreat Health Care; Maria Basescu, Retreat Health Care; Scott Thompson, Independent LCMHS.

Staff
Paul Blake, Beth Tanzman, John Howland, Bill McMains, Wendy Beinner

Introductions were made and a recent membership list circulated.

Work Group Reports

In Patient Work Group
Bill McMains, Chair of the work group reviewed the charge, the composition of the work group, and its activities to date. The work group offered the full advisory committee a recommendation on the criteria to use to select sites and partners for the VSH replacement inpatient capacities. Bill noted that the proposed selection criteria passed without dissent and this recommendation reflect the work group's strong, consensus opinion. Anne stated that the criteria do identify potential partners and sites; specifically the only hospital that can meet the primary facility criteria is Fletcher Allen Health Care. In addition, the only hospitals that could meet the smaller capacity criteria are those that currently operate psychiatric inpatient services. The group reviewed the criteria for the primary site as proposed by the work group:

Primary Site & Partner Selection Criteria

1. The primary VSH replacement service should not be an IMD
2. It should be attached to or near (in sight of) a tertiary / teaching hospital
3. Only designated hospital inpatient providers shall be considered for the primary VSH-replacement program until such time as it is

demonstrated that an agreement cannot be negotiated with one of these partners.

4. There must be adequate space to develop or renovate a facility that will accommodate census needs.
5. The partner must agree to participate in the care management system. This assures a single standard of care, common clinical protocols, zero reject of eligible admissions etc.
6. Costs - both ongoing operations and capital construction - should be considered.
7. Outdoor activity space should be readily accessible to the units.
8. The ability to attract and retain sufficient specialty staff experienced in psychiatric care should be demonstrated.
9. The proposed partner's motivation, track record, and experience in partnering with the state and system of care should be considered.
10. Openness and past experience in including consumers/stakeholders in program design and quality monitoring should be demonstrated.
11. Willingness to participate in a public reporting of common quality standards is required.
12. Ability to deal with expedited planning time frame for full implementation to out-pace five year timeline.
13. Ability to collaborate with neighbors.
14. Ability to work closely with state and designated agency partners

Discussion

Ed asked what the rationale for criteria # 3 (only DH inpatient providers considered as partners) was. Work group members offered the following:

- Designated Hospital psychiatric inpatient programs have the infrastructure in place, the clinical expertise and the ability to recruit specialty staff
- They have historic commitment to do the work
- We need to maintain the existing capacity in the system

Larry, stating that while he endorsed these criteria as a member of the inpatient work group, also observed that from the VSH staff point of view, many might prefer an arrangement with Copley Hospital because it would be closer geographically to the current VSH work force. But he wasn't sure how realistic it would be for Copley to operate a VSH-level service. Ken offered that part of the resolution being proposed to the Advisory Committee is to say that we are looking to Fletcher Allen to be the primary player. He expressed concern that we may need a back-up plan if Fletcher Allen doesn't work out. Ken also stated that such a work group would endorse FAHC as the primary site for VSH replacement is testimony to the hard work of FAHC and how much they have progressed in the mission to serve the public mental health system. Bea observed that there is an opportunity now, to talk with the leadership at FAHC and get a concrete conversation started. Anne concurred, saying we have narrowed the range of options to FAHC as the first choice. Kitty asked how would transportation work? This keeps the

service in one place and far away from many consumers and families. Bill stated that this is an important concern and must be addressed. Other members expressed concern that this essentially "puts all our eggs in one basket" and would it weaken the state's bargaining position? Work group members offered that FACH is the preferred site as a matter of policy and that a recommendation from the Advisory Committee is needed to start the negotiation with FAHC.

The group reviewed the criteria for the smaller capacity(s) as presented:

Smaller Inpatient Capacity(s)
Site and Partner Selection Criteria

1. Preference should be given to Designated Hospital inpatient providers until such time as it is demonstrated that an agreement cannot be negotiated with one of these partners.
2. A location consideration is to assure adequate distribution of services throughout the state.
3. Ability to provide adequate on-site medical care and demonstrated access to hospital medical services.

The rest of the criteria are the same as for the primary site

Anne offered a comment on #3 (ability to provide adequate on-site medical care . . .) stating that this is particularly to allow the Brattleboro Retreat to be a partner even though they are a stand alone psychiatric hospital and not integrated on the campus of a general medical hospital. She shared her own thinking about why this was appropriate in the case of the Retreat. Namely, this is a smaller capacity (not the primary), it helps with geographic distribution, the Retreat is essentially "grand-fathered" into our system and it is not the same as creating a new hospital. Finally other existing full size specialty hospitals do not necessarily promote stigma – Sloan Kettering doesn't stigmatize cancer patients. Anne concluded stating strong support for the recommended criteria # 3.
Ken offered that the work group deliberations clearly reflect that the smaller capacities were going to have to live up to a much higher standard than they currently do – this is not simply about "repainting a few rooms". The work group's intention is to set a much higher standard for the smaller sites for the VSH replacement service.

Public comment was taken.

- Bea made the motion: <u>The Futures Advisory Committee should accept the criteria as developed by the inpatient work group</u>. Seconded by Anne. No further discussion.

- Anne moved to add one new criteria to the set: <u>The partner must be prepared to commit to support of the state public policy goal to work towards a system that</u>

does not require coercion or the use of involuntary medication. Seconded by Ed. Discussion followed re the amendment.

The vote on the amendment was 16 in favor; 1 abstention (Peter Tomashow). The amendment passed.

Next the committee voted on the overall set of amended criteria. The criteria passed with 14 votes in favor; 1 opposed (Michael Sabourin); and 2 abstentions (Linda Corey and Conner Casey).

Next the advisory committee turned to a general recommendation made by the inpatient work group as stated below:

"*Planning for the Futures project, for both inpatient and community services needs to occur in the context of considering the overall financial health of the Designated Hospital and Agency service providers.*"

- Ed moved that "the advisory committee accept the recommendation as stated". This was seconded by Anne.
- Anne moved that the recommendation be amended to include the following statement and Linda seconded:

"The VSH Futures Advisory Committee notes that its "support in concept" for the overall Futures plan, and its formal votes regarding advancing specific components, all remain contingent upon the scope of the plan as presented to the legislature last February. We do not believe that a replacement inpatient unit alone with or without the addition of sub acute beds can succeed in meeting the needs of the population that VSH serves. These components include the addition of emergency observation, diversion and step-down beds, additional housing, additional community services, additional peer support services, and non-traditional alternatives. It also assumes continuation of adequate resources to sustain all existing community services and caseload growth. The Committee notes that the expectation is that it will see appropriate activities and funding for these components in the FY 07 budget in accordance, at a minimum, with the programs identified as and budgeted as coming on line in FY 07 in the time line that targets a new inpatient facility opening in June, 2010; and that any expedited time line would also expedite the associated program components in the budget."

Discussion followed with multiple advisory committee members stating that the inpatient replacement, the sub acute programs and the secure residential will not work unless these other resources are developed and the overall sustainability of the system is addressed. Anne accepted friendly amendments to include Designated Hospitals specifically and to state that this position is based on our past experience. Members of the sub acute / secure residential work group stated that the work group would strongly support this motion as worded.

The motion as amended passed with 16 in favor and 1 abstention.
Public comment was taken.

Sub Acute / Secure Residential Work Group
Michael Hartman gave the report. Northeast Kingdom Human Services has located a second potential program site that would be big enough to accommodate both a sub acute and secure residential program. The sub acute program proposed in Vergennes is unlikely to get through the zoning process before January 2006. The work group has informally reviewed VSH patients who may be candidates for the sub acute programs and is recommending that the individual DAs who will run these programs step up their interactions with the VSH patients and staff. Work continues to understand the legal tools available within the existing statutory framework and the group has met with Jack McCullough and Wendy Beinner. Program developers are uncertain that the existing tools can be stretched enough to work for this new level of care. The program standing committees of both the Howard Center and the Counseling Services of Addison County have visited the proposed building and are involved in developing the program operations. JoEllen asked how many patients at VSH had been identified as potential candidates for the sub acute programming. Michael estimated that at each review point, between 12 – 20 patients have been identified. Michael affirmed that the plans are to restrict the initial client pool to VSH residents in order to help reduce the pressures on the current VSH. Anne stated that it will be critical to develop a clear strategy for how to "close" the VSH beds behind the clients admitted to sub acute in order to really have an impact on the VSH census. Michael emphasized that the work group is open to consumer and family participation. **The next work group meeting will be November 30th, 9:00 – 11:00 @ Tom Simpatico's VSH office (across from the VSH Canteen).**

Care Management Work Group
Nick Emlen reported that the Care Management work group has divided itself into two subgroups: one focused on the movement of clients across the system of care and the second on defining the clinical characteristics and programmatic levels of care. Nick reviewed a draft of the developing principles for the movement of clients group. Anne encouraged members of the public and consumers / families to attend the work group meetings. Nick offered the context that the care management system is necessary due to the increasing decentralization of the system and the importance of insuring that Vermonters have access to the care that they need. The care management system will require more information technology than we have now. Bea emphasized the importance of developing very specific criteria for admission and discharge at each level of care and that these criteria need to be easily communicated and understood throughout the system. Kitty observed (re: principle 1.12) that peers should not be the only ones responsible for informing patients of their rights. **The next meeting of the care management work group will be December 16th at 9:00 – 11:00 at Central VT Hospital Conference Room 2.**

Public comment was taken.

<u>Crisis Stabilization Discussion:</u>
Beth introduced the topic by reviewing the current programs providing crisis stabilization and described an "observation bed" linked to a general hospital as a different approach. She requested the committee's thoughts on what sort of crisis stabilization approach

would be most needed in the system currently. In addition, she requested input on where any new capacities should be targeted. Anne observed that it may require looking at each service area individually to identify gaps and unique local solutions. She pointed out that in general hospital care there is an "observation" admission status that affords time to make the best treatment decisions. Also, that lack of crisis stabilization resources has been identified as a priority by most communities. Ed stated that he didn't have the clinical expertise needed for this type of discussion, and what we seem to be describing is a linked network of services with different levels of intensity. Why think only of beds? Why not think of "roofs"? Ed described a different model to look at – the NH peer run respite program called Stepping Stones. This service is very complimentary to the formal system and he called on the group to use consider how to fertilize our discussion to include other types of options. Anne pointed out that in the work plan for this spring is a work group charged with looking at alternative supports – so let's not allow this to get lost. Charlie pointed out that it is hard to definitively discuss or choose among models for crisis stabilization because what people need in crisis is very individual. Linda concurred that Stepping Stones is a great program and also shared that the director, Sherry Mead, is training Vermonters in this approach. Anne pointed out that a goal of the system is to provide care, including crisis stabilization and support; close to home and that currently this is not a reality in Vermont. She emphasized the importance of providing local teams with the options to take more time to evaluate the needs of a person in crisis while providing safe support. When asked how to move this discussion towards closure meeting participants offered that this topic needs its own subgroup, needs more input from the emergency service directors, requires a sharper definition of what need is being addressed with crisis stabilization and how safety will be achieved.

Public comment was taken.

Community Resources Survey

Beth passed out a one page form designed to help capture the relative priority for developing the community resources identified in the Futures planning to date. She emphasized that all the proposed services are important; however as we can only do so much at once, it would be helpful to get the larger group's (both committee members and interested parties) about the relative priorities for development. Participants agreed to fill out the survey by email reminder.

Updates

The RFP for actuarial services to help assess the number of psychiatric inpatient beds VT will need was issued. Copies were made available to committee members and it is posted on the VDH website HealthyVermonters.com . Members requested copies of the RFP issued by Buildings and General Services for the preliminary architectural work – this was posted on the VDH website November 18th. Beth also informed the group that it has been difficult to schedule time with lawyers for legal issues; she committed to organizing a meeting on the broadest legal issues raised (advanced directives, substitute judgment) and to feed the Futures-specific legal issues into existing work groups.

The meeting adjourned at 12:30 pm